ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Michelle Anderson / Programmer
Name and Title of Individual *(typed or printed)*

Task / Role of this individual in this project	Company / Organization
Programmer / Analyst	DHCFP

Street Address: 2 Boylston Street

City	State	ZIP Code
Boston	MA	02116

Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*
617 988 3283	Michelle.Anderson@state.MA.us
Signature of Individual: Michelle Anderson	Date: 6-8-2010
Signature of CMS Representative	Date
Signature of CMS Project Officer *(If applicable)*	Date

Name and Title of Individual *(typed or printed)*

Task / Role of this individual in this project	Company / Organization

Street Address

City	State	ZIP Code

Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*
Signature of Individual	Date
Signature of CMS Representative	Date
Signature of CMS Project Officer *(If applicable)*	Date

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for: MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* John Cai		
Task / Role of this individual in this project Analyst	Company / Organization Division of Healthcare Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3137	E-Mail Address *(If applicable)* john.cai@state.ma.us	
Signature of Individual X	Date 06/09/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Chris Campeau		
Task / Role of this individual in this project Software Engineer	Company / Organization MA DHCFP	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02114
Office Telephone *(Include Area Code)* (617) 988-3154	E-Mail Address *(If applicable)*	
Signature of Individual	Date 06/07/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Michael Cheung, Health Policy Analyst		
Task / Role of this individual in this project Programmer, Analyst	Company / Organization	
Street Address 2 Boylston Street 5th Floor		
City Boston	State MA	ZIP Code 02111
Office Telephone *(Include Area Code)* (617) 988-3165	E-Mail Address *(If applicable)* Michael.Cheung@hcf.state.ma.us	
Signature of Individual Michael Cheung	Date 06/08/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Stacey Eccleston		
Task / Role of this individual in this project Manager of Health Care Cost Containment	Company / Organization Division of Healthcare Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3276	E-Mail Address *(If applicable)* stacey.eccleston@state.ma.us	
Signature of Individual Stacey Eccleston	Date 06/09/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)*		
Thomas S. Faiella		
Task / Role of this individual in this project	Company / Organization	
Database Administrator	DHCFP	
Street Address		
2 Boylston Street		
City	State	ZIP Code
Boston	Ma	02116
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
617-988-3187	Thomas.Faiella@State.Ma.US	
Signature of Individual	Date	
Thomas S Faiella	06/08/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* ROGER FENG		
Task / Role of this individual in this project SOFTWARE ARCHITECT/DEVELOPER	Company / Organization MASS DHCFP	
Street Address 2 BOYLSTON ST		
City BOSTON	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* 617-988-3253	E-Mail Address *(If applicable)* ROGER.FENG@STATE.MA.US	
Signature of Individual Roger Feng	Date 6/8/10	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Michael Grenier, Pricing Policy Manager		
Task / Role of this individual in this project Manager of payment reform projects	Company / Organization Division of Health Care Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3192	E-Mail Address *(If applicable)* michael.grenier@state.ma.us	
Signature of Individual	Date 06/23/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* GETACHEW HABTEH-YIMER		
Task / Role of this individual in this project Analyst	Company / Organization Division of Healthcare Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3131	E-Mail Address *(If applicable)* getachew.habteh-yimer@state.ma.us	
Signature of Individual Getachew Habteh Yimer	Date 06/09/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Elizabeth Harney / Project Leader		
Task / Role of this individual in this project IT Project Leader	Company / Organization Commonwealth of Massachusetts / DHCFP	
Street Address 2 Boylston Street / 5th Floor		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3288	E-Mail Address *(If applicable)* betty.harney@state.ma.us	
Signature of Individual Elizabeth Harney	Date 6-4-2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures". If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Young Joo, Health Policy Analyst		
Task / Role of this individual in this project Analyst	Company / Organization MA Division of Health Care Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3241	E-Mail Address *(If applicable)* young.joo@state.ma.us	
Signature of Individual	Date 06/04/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Chris Kane		
Task / Role of this individual in this project Applications Manager	Company / Organization Division of Health Care Finance And Policy	
Street Address 2 Boylston St		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* 617 988-3274	E-Mail Address *(If applicable)* Chris.kane@state.ma.us	
Signature of Individual Chris Kane	Date 6-8-2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

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Name and Title of Individual *(typed or printed)*		
Michael Lichtman Database Administrator		
Task / Role of this individual in this project DBA	Company / Organization Commonwealth Of Mass DHCFP	
Street Address 2 Boylston St.		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3157	E-Mail Address *(If applicable)* michael.lichtman@state.ma.us	
Signature of Individual Michael Lichtman	Date 06/08/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Sonja Lee-Austin Health Policy Analyst		
Task / Role of this individual in this project Analyst	Company / Organization MA Division of Health Care Finance & Policy	
Street Address 2 Boylston St., 5th Floor		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3113	E-Mail Address *(If applicable)* Sonja.Lee-Austin@state.ma.us	
Signature of Individual Sonja Lee-Austin	Date 06/04/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts' Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Thinzar Mra Min

Name and Title of Individual *(typed or printed)*
Director of Health Care Data Analytics

Task / Role of this individual in this project	Company / Organization HCF

Street Address
2 Boylston St.

City Boston	State MA	ZIP Code 02116

Office Telephone *(Include Area Code)* (617) 988-3153	E-Mail Address *(If applicable)* thinzar.min@state.ma.us
Signature of Individual	Date 6/6/10
Signature of CMS Representative	Date
Signature of CMS Project Officer *(If applicable)*	Date

Name and Title of Individual *(typed or printed)*

Task / Role of this individual in this project	Company / Organization

Street Address

City	State	ZIP Code

Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*
Signature of Individual	Date
Signature of CMS Representative	Date
Signature of CMS Project Officer *(If applicable)*	Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ADDENDUM TO DATA USE AGREEMENT (DUA)

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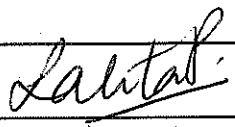
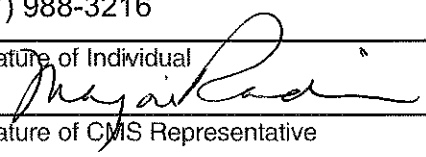
Name and Title of Individual *(typed or printed)* LALITA PULAVARTI		
Task / Role of this individual in this project Analyst/Principal Tester	Company / Organization DHCFP/Health Data Analytics	
Street Address 2 Boylston Street, 4th Floor		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3110	E-Mail Address *(If applicable)* Lalita.Pulavarti@state.ma.us	
Signature of Individual 	Date 06/04/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Form Approved
OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Marjorie Radin		
Task / Role of this individual in this project Claim-level analysis	Company / Organization Division of Health Care Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3216	E-Mail Address *(If applicable)* marjorie.radin@state.ma.us	
Signature of Individual 	Date 06/10/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ADDENDUM TO DATA USE AGREEMENT (DUA)

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Name and Title of Individual *(typed or printed)* Amy Smalarz, PhD Director of Performance Measurement		
Task / Role of this individual in this project Project Specific management	Company / Organization Division of Health Care Finance and Policy	
Street Address 2 Boylston St		
City Boston	State Ma.	ZIP Code 02116
Office Telephone *(Include Area Code)* 617-988-3213	E-Mail Address *(If applicable)* amy.smalarz@state.ma.us	
Signature of Individual Amy Smalarz	Date 6/7/10	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Paul Smith / Health Policy Analyst		
Task / Role of this individual in this project Analyst, Principal Tester	Company / Organization MA Division of Health Care Finance and Policy	
Street Address 2 Boylston St		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3242	E-Mail Address *(If applicable)* paul.smith@state.ma.us	
Signature of Individual Paul R. Smith	Date 6/4/10	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

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ADDENDUM TO DATA USE AGREEMENT (DUA)

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Name and Title of Individual *(typed or printed)* Nga Vuong, Health Policy Analyst		
Task / Role of this individual in this project Analyst, principal tester	Company / Organization Division of Health Care Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* 617-988-3170	E-Mail Address *(If applicable)* nga.vuong@state.ma.us	
Signature of Individual Ngavuong	Date 06/07/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)* Julia Wenger		
Task / Role of this individual in this project Analyst	Company / Organization Division of Healthcare Finance and Policy	
Street Address 2 Boylston Street		
City Boston	State MA	ZIP Code 02116
Office Telephone *(Include Area Code)* (617) 988-3364	E-Mail Address *(If applicable)* julia.wenger@state.ma.us	
Signature of Individual	Date 06/09/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

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OMB No. 0938-0734

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for MA DHCFP's "The Role of Publically Financed Insurance in Massachusetts Health Care Expenditures." . If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

Name and Title of Individual *(typed or printed)*		
DEBORA YEE WONG		
Task / Role of this individual in this project	Company / Organization	
Programmer / Analyst	DIVISION HEALTH CARE FINANCE AND POLICY	
Street Address		
2 BOYLSTON STREET, BOSTON, MA		
City	State	ZIP Code
BOSTON	MA	02116
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
617.988.3281	DEBORA.WONG@STATE.MA.US	
Signature of Individual	Date	
[signature]	6/8/2010	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	

Name and Title of Individual *(typed or printed)*		
Task / Role of this individual in this project	Company / Organization	
Street Address		
City	State	ZIP Code
Office Telephone *(Include Area Code)*	E-Mail Address *(If applicable)*	
Signature of Individual	Date	
Signature of CMS Representative	Date	
Signature of CMS Project Officer *(If applicable)*	Date	